TRAUMA ADVISORY COUNCIL
Janaury 25, 2007
Minutes

Members Present:

Dr. Doug Norcross (Chairman)
Dr. Mark Reynolds
Mr. Troy Powell
Dr. Linda Veldheer
Dr. Raymond Bynoe
Mr. Lanny Bernard
Dr. Troy Privette
Dr. Todd Carlson
Ms. Alice Ammons (for Cathie Osika-Landreth)
Dr. Ed DesChamps
Ms. Kelly Hawsey
Ms. Jane Marlowe
Mr. George Johnson
Ms. Terri Schumpert
Dr. Lars Reinhart

Others Present:

Ms. Wilma Bocanegra
Ms. Katrina Gary
Mr. Alonzo Smith
Mr. Jim Walker
Mr. Greg Kitchens
Ms. Debbie Cuillard
Ms. Carol Ann Dean
Ms. Lisa LeMay
Ms. Tammy Allison
Ms. Diane Howell
Mr. Marion Stewart

Agenda Items		**Motions/Actions Taken**
Call to Order/Roll Call	The meeting was called to order at 10:00 am followed by roll call.	
April 27, 2006 Minutes		A motion was made to approve the April 27, 2006 minutes. The motion was seconded. The motion was approved.
Chairman's Comments	Dr. Norcross welcomed everyone to the meeting and introduced Mr. Greg Kitchens as the new Trauma Manager.	
	Dr. Norcross stated that the new green book (Optimal Care of the Injured Patient) has been published and replaces the gold book. This lists the standards for trauma centers nationwide by the American College of Surgeons (ACS). Dr. Norcoss stated that the standards have most likely changed, which will require a committee to review these standards and report their recommended changes to the Trauma Advisory Council.	A motion was made for the EMS Division to form a committee and coordinate meetings, with Dr. Raymond Bynoe serving as chairman, to review the guidelines in the green book (Optimal Care for the Injured Patient) and make recommendations to the Trauma Advisory Council on how to bring South Carolina's guidelines current with ACS standards. The motion was seconded. The motion was approved.
	Ms. Alice Ammons stated that the green book can be ordered through the ACS website: www.FACS.org/programs/trauma	

	Mr. Alonzo Smith agreed to procure some of these books.	
Committee Membership	Dr. Norcross stated that there are several memberships on the Trauma Advisory Council that needs to be filled. The South Carolina Chapter of the ACS needs to appoint a surgeon from a level II, the Hospital Association needs to appoint an administrator from a level II and the College of Emergency Physicians needs to designate an emergency physician from a level II.	
Application Process for Level I Trauma Centers	Ms. Alice Ammons informed the Council that the Trauma Association of South Carolina (TASC) identified some inconsistencies in the level I re-designation/application process. She stated that TASC was unsure of what data was required for the application. She stated that TASC would like to look at the application to come up with a consensus of required information. She stated that some of the information asked for could not be readily queried from the Trauma Registry. She also stated that the same inconsistencies would apply for level II and level III applications.	A motion was made for The Trauma Association of South Carolina (TASC) to form a committee to make recommendations for revision to the application process. The motion was seconded. The motion was approved.
Regional Meetings	Mr. Alonzo Smith stated that at the July 28, 2005 Trauma Advisory Council	

	Meeting, a motion was approved to elect the following as representatives for regional meetings: Mr. Lanny Bernard; Midlands Region, Mr. Don Lundy; Low Country Region, Dr. Mark Reynolds; Pee Dee Region and Ms. Cathy Osika-Landreth; Upstate Region. Mr. Smith informed the Council that Midlands Region is the only region that has had a regional meeting. Dr. Bynoe stated that the problem is getting everyone to come to the table for discussion. He stated that hospital administrators need to be more involved in these meetings. Dr. Bynoe also said that non-trauma centers are reaping the benefits of having a trauma center in their region and should be involved as well. Mr. Lanny Bernard stated that Ms. Phyllis Beasley (former Trauma Manager), along with representatives from the various regions, was responsible for coordinating regional meetings. After some discussion, it was agreed that regional meetings would be re-organized by the EMS office and local people from various regions. Mr. Alonzo Smith stated that Mr. Greg Kitchens will be in charge of continuing to	

	coordinate regional meetings but that Mr. Kitchen's first priority is to tackle some of the core issues facing trauma, such as the designation and re-designation process. He stated that East Cooper has applied for Level III designation, which is one of Mr. Kitchen's top priorities. There was a concern; however, if the application and re-designation process would come under the present ACS standards or the revised standards. Dr. Norcross stated that if applications are received prior to the application revisions recommended by the TASC committee, or before the recommendations by the committee to review the new green book standards (Optimal Care for the Injured Patient), then the present standards will apply. It was agreed that the coordination of regional meetings will be held off for at least three months until Mr. Greg Kitchens takes the crash course in South Carolina Trauma System.	
Staff Report	Mr. Alonzo Smith thanked everyone involved in helping with the hiring process for the Trauma Coordinator (Mr. Greg Kitchens). Mr. Smith stated that Mr.	

	Kitchens has a very strong EMS background and will acquire a very strong hospital background as he becomes more involved in working with hospitals on trauma issues. Mr. Kitchens has already been working on trauma protocols and guidelines through medical control and his involvement through EMS. Dr. Norcross asked that Mr. Kitchens forward him copies of the trauma protocols. Mr. Smith stated that a proviso is in place regarding trauma funds for the regions, which allows for eleven percent of the funds to be sent to the EMS regions, ten percent to the counties and seventy-seven percent to hospitals and physicians. He further stated that funds have been disbursed to the regions for EMS training towards getting more intermediate EMTs and Paramedics into the field. The first installment of $110,000 to each of the regions was taken out of the actual reoccurring $4,000,000. The supplemental funds have been received and are being set up for disbursement. This will give the regions an additional $55,000, which will clear out the remaining funds for which they are entitled according to the proviso. Additionally, the Trauma Advisory Council will be working on guidelines to	

	determine how to disburse the funds allotted to hospitals and physicians. Mr. Smith stated that the bioterrorism guidelines have changed significantly in that they're no longer funding a lot of trauma related issues. Mr. Smith also stated that these two trauma positions, (Administrative Assistant and the Trauma Coordinator) have basically depleted the two percent that the EMS Division was entitled to. Mr. Smith shared his concern that these funds may have to be spent within a certain period of time. He stated that the proviso didn't specifically stated that the money could be carried forward. He said that as soon as guidelines for disbursement are approved, he can develop contracts for distribution before the end of fiscal year Discussion centered on forming a task force to come up with recommendations for disbursing these funds. Members elected to this task force are Dr. Raymond Bynoe, Mr. Troy Powell, Dr. Doug Norcross., Mr. Wm Manson, Mr. Jeff White, Dr. Mark Reynolds, Ms. Alice Ammons, Ms. Tammy Allison, Ms. Jane Marlowe, Dr. Ed DesChamps and Ms. René Kilburn and Mr. Jim Walker. Dr. Norcross asked those members who	Ms. Alice Ammons made a motion that the chairmen appoint a task force consisting of three hospital administrators, three physicians and three trauma program managers by trauma level to develop recommendations for distribution of the 2006 trauma funds and report back to the Trauma Advisory Council as soon as possible, with DHEC to arrange meetings of this task force. A second motion was made to amend the first motion to include an administrative representative from

	were present to meet with him after the Trauma Advisory Council meeting was adjourned. Mr. Alonzo Smith asked Mr. Lanny Bernard to help form a committee to come up with recommendation(s) for the EMS Advisory Council to disburse the county funds as soon as possible. Mr. Smith also asked for volunteers to sit on this committee. Ms. Terri Schumpert volunteered to sit on this committee. Dr. Bynoe asked if there is a way to determine which county will receive the funds. Mr. Smith stated that the determination will likely be based on the counties with the highest trauma mortality rates.	rehabilitation. The motion was seconded. The motion was approved.
TASC Report	Ms. Alice Ammons reported that The Trauma Association of South Carolina (TASC) had their Trauma Symposium on November 9-10, 2006, with approximately 150 attendees from South Carolina, North Carolina and Georgia. This was the first time that the Association offered CMEs, with one physician participating. Next year's symposium will be November 8-9, 2007. Dr. Norcross stated that the Trauma	

	Association of South Carolina (TASC) is an independent group composed of Trauma Registrars and Trauma Nurse Coordinators who advise the Trauma Advisory Council on various trauma issues. Dr. Norcross and Dr. Bynoe thank the members of TASC for their hard work.	
Advisory Council Report	Mr. Alonzo Smith stated that the communications committee continues to work on a statewide communications system and will be involved in appropriating funding for an 800-system. Mr. Jim Catoe is coordinating this meeting. Mr. Smith also stated that the training committee has been looking at online in-service training. Mr. Smith stated that Medical Control has been concerned about the certification and competency level of medics in the field. He stated that any number of medics have been re-certified several times without having to take a practical or written exam, because the in-service training program allows a physician to approve the practical skills and the written component. This has increased litigation regarding medics in the field. He stated that a young man (Nathaniel Patterson) that will be doing a research study regarding the competency level of medics in the field and will work with Medical Control to find out what the real issues are, i.e., does the problem lie	

	with the exam itself, with the instructor or with the student, etc. Findings will be reported to the EMS Advisory Council and the Trauma Advisory Council when they become available. Mr. Smith reported that all exams are now computer-based as of January 1, 2007. All medics will be tested via computer to determine competency. Mr. Smith also stated that a strategic planning committee has been formed to help develop a road map or business plan to guide the implementation of the NEMSIS data project in South Carolina.	
HOSCAP/Collector	Ms. Katrina Gary reported that all trauma centers are now using HOSCAP. She stated that she's training non-trauma HRSA hospitals on the use of HOSCAP as well. She also reported that trauma centers are required to update their information in HOSCAP on a daily basis. Some hospitals update their information twice a day and sometimes more often, depending on the hospital's scenario. Ms. Gary stated that her next step is to educated helicopter providers because some of their information is not as updated as it should be, specifically their contact information. Ms. Gary informed the Council that the Trauma Registry update was put on hold because of contractual issues with DHEC and Digital Innovations. This problem has been resolved and they're in the final	

	testing phase. Once these updates are final, the Trauma Registry and Data Dictionary will be available. Dr. Norcross asked if there is a correlation between HOSCAP and an upcoming disaster drill in the low country. Ms. Gary stated that HOSCAP does include a drill site on the opening page that should be used for disaster planning and for drills. Further discussion centered on ways to get trauma issues to the public, i.e., through commercials, through prominent people from around the area, through media events and through public service announcements, etc. The Council will entertain these and other ideas at a later date.	
Next Three Meetings	April 26, 2007, July 26, 2007 and October 25, 2007	
Adjournment	There being no further business to discuss; the meeting was adjourned at 1:00 P.M.	

TRAUMA ADVISORY COUNCIL
April 26, 2007
Minutes

Members Present:
Dr. Doug Norcross (Chairman)
Dr. Mark Reynolds
Mr. Troy Powell
Dr. Linda Veldheer
Dr. Paul Banish
Don Lundy
Dr. Jim Foster
Laurie Havice
Dr. John Davies
Bill Manson
Rene Kilburn
Mr. Lanny Bernard
Jack Derrick for (Ms. Kelly Hawsey)
Dr. Lars Reinhart
Dr. John Chandler
Ms. Terri Schumpert
Cathie Osika-Landreth
Dr. Troy Privette
Dr. Raymond Bynoe

Others Present:
Mr. Greg Kitchens
Ms. Katrina Gary
Mr. Alonzo Smith
Mr. Jim Walker
Ms. Alice AMmons
Ms. Debbie Cuillard
Ms. Tammy Allison
Ms. Nancy Owens
Mr. Marion Stewart

Agenda Items		**Motions/Actions Taken**
Call to Order	The meeting was called to order at 10:00 am.	
April 26, 2007 Minutes		A motion was made to approve the January 25, 2007 minutes. The motion was seconded. The motion was approved.
Chairman's Report	Dr. Norcross reported that the ACS Standards Subcommittee will meet on May 8, 2007 to look at the new criteria to decide which one(s) will be used. He reported that TASC has met to look at the designation application forms, but this is on hold pending on the report of the ACS Standard Subcommittee. The hospital/physicians funds disbursement committee has met a number of times and will be making a report at this meeting.	
Staff Report	Mr. Greg Kitchens and the committee welcomed Dr. John Davies and Ms. Laurie Havice as new members to the Trauma Advisory Council Committee.	
Trauma Registry/HOSCAP Update	Ms. Katrina Gary reported that she is still handling ongoing issues with HOSCAP and the University of Washington. She reported that DHEC may have to cease the use of HOSCAP for the following reasons: • The new contract, in several sections/paragraphs, references protected	

	health information or PHI. At no time has DHEC requested any PHI as such be related, obtained, inputted or disbursed. Thus, all clauses pertaining to PHI are irrelevant to SC DHEC, EMS' initial HOSCAP agreement. • There is a new clause pertaining to the SC Tort Claims Act. Due to prohibition by SC Law, we cannot indemnify or hold harmless any entity. • The University of Washing/Harborview wants DHEC to take out an insurance policy (for HOSCAP) that benefits a third party or subcontractor. DHEC maintains a modest insurance policy in the form of general liability through the State of South Carolina. The insurance issue is not one we can negotiate. Washington state does not have a tort claim cap and cannot be put in a position of absorbing risk from other states. DHEC EMS will consider using WEBEOC or other alternatives.	
ABLS Course	Greg Kitchens reported that the ABLS (Advance Burn Life Support), an online course, is now being offered to level III trauma centers. This course was offered to level I and level II trauma centers last year. These slots have already been funded for anyone at level III trauma centers interested in this course. This program has been approved by AACN Certification	

	Corporation under established AACN Certification Corporation guidelines for seven (7) contact hours, CERP Category A. The American Burn Association is accredited by the Accreditation Council for Continuing Medical Education. The ABA designates this continuing medical education activity for up to six (6) credits in Category 1 of the Physician's Recognition Award of the American Medical Association. ABLS Now© is designed in a multidisciplinary format and is based on the guidelines for initial burn care developed by the American Burn Association. The ABLS Provider Course presents a series of didactic presentations on: ♦ Initial Assessment and Management ♦ Airway Management ♦ Smoke Inhalation Injury ♦ Shock and Fluid Resuscitation ♦ Burn Wound Management ♦ Electrical Injury ♦ Chemical Burns	

	♦ Pediatric Burn Injuries ♦ Stabilization, Transfer and Transport ♦ Disaster Management and the ABA Plan ♦ Case Studies Anyone interested in completing this course should contact Greg Kitchens or Wilma Bocanegra at DHEC EMS Division (803 545-4204). The e-mail address for Greg Kitchens is kitchege@dhec.sc.gov. and Wilma Bocanegra's e-mail address is bocanew@dhec.sc.gov.	
Trauma Website	Mr. Kitchens stated that the trauma website is in the process of being updated and will be an invaluable asset in supporting the trauma system in South Carolina.	
ACS Books/Criteria Review	Mr. Kitchens stated that the ACS Green Book (Optimal Care of the Injured Patient) is on hand and TAC members may obtain a copy from him after the meeting. Mr. Kitchens also provided information on federal legislature regarding the trauma system. He stated that Washington is working towards re-organizing the trauma system and trying to get money	

	($12,000,000) in federal funding. This is being done under the Trauma Care Systems Development Act of 1998.	
New Business: Statewide Triage Protocols	Dr. Norcross stated that a state-wide regionalized trauma system must operate under one rule. This means that all EMS services must follow the same rule and guidelines regarding trauma center transport. Dr. Norcross provided a copy of the new ACS standards (Optimal Care of the Injured Patient), page 22, which includes a field triage decision scheme. Several minor changes were made. These are: 1) If revised trauma score (RTS) is ≤ 12 upon EMS evaluation, age appropriate hypertension and respiratory rate is < or > 29, transport patient to the nearest designated trauma center. Air transport or bypass of level III trauma center to level I or level II trauma center should be considered if distance and circumstances are appropriate and/or no level III trauma center is available. Burn patients are to be transported in the same manner. 2) Penetrating injuries to head, neck, torso, etc., should be taken to the nearest trauma center. Air transport or bypass of level III trauma center to level I or II trauma center should be considered if distance and	A motion was made to forward changes to the triage decision scheme to the Medical Control Committee and the EMS Advisory Council for approval as the statewide triage protocol. The motion was seconded. The motion was approved.

	circumstances are appropriate and/or no level III trauma center is available. 3) Falls: 20 ft. in adult (one-story = 10 feet), children: 10 ft. or two to three times the height of a child; intrusion > 12 inches occupant side; intrusion >18 inches on any side; ejection (partial or complete) from automobile; death in same passenger compartment; pedestrian struck by vehicle, thrown, run over, or with impact >20 MPH; bicyclist thrown, run over, or with impact >20 MPH, and motorcycle crash >20 MPH, should be transported to the closest available trauma center. A lower level trauma center should not be bypassed for transport to a higher level trauma center. If no trauma center is available, transport to closest appropriate hospital emergency department for evaluation and transfer as necessary. Air transport from incident scene is not appropriate. 4) Medical Control should be contacted prior to transport for older adult and children, patients with bleeding disorders or an anticoagulation medication; end stage renal disease requiring dialysis and pregnancy >20 weeks. Transport to the closest available trauma center should be considered. A lower level trauma center should not be bypassed for transport to a higher level trauma center. If no trauma	

	center is available, transport to the closest appropriate hospital emergency department. **Decision to call on-scene air transport should come from South Carolina certified personnel associated with a South Carolina licensed EMS or first responder agency.**	
Old Business: Distribution of EMS funds subcommittee report	Mr. Lanny Bernard stated that the committee met and decided to grant the funds to the top fifteen counties with the highest trauma mortality rate for a motor vehicle per capital (100,000) people. This gave each county $40,000 to be used for equipment or training that is directly related to trauma. Mr. Lundy stated that the committee also established guidelines for how this money is to be used.	A motion was made to approve the EMS funds disbursement subcommittee recommendation for the distribution of funds to the fifteen counties with the highest trauma mortality rate for a motor vehicle per capital (100,000) people. The motion was seconded. The motion was approved.
Distribution of Hospital/Physicians funds subcommittee report	Dr. Norcross passed out the subcommittee recommendation for distribution of the 2006 hospital/physician funds. He stated that the Trauma Advisory Council must make an approval for disbursement of these funds at this meeting. The breakdown of the $6,000,000 on the long-term plan is as follows: 1) 1.4 million goes to DHEC EMS for disbursement as recommended by the EMS disbursement subcommittee; and 2) 4.6 million dollars for hospitals and physicians.	A motion was made to approve the short-term disbursement plan submitted by the funds disbursement subcommittee for hospitals and physicians. The motion was second. The motion was unanimously approved.

	Rehabilitation will be included in the long term plan. He stated that Medicaid will not pay for free-standing rehabilitation centers in the State of South Carolina Medicaid. He also stated that the long range plan will give 5% of the funds to rehabilitation. The reason for a long term plan is because there is no plan yet to distribute this money among free-standing rehabilitation centers. Dr. Norcross stated that the short-term plan for distribution of the $6,000,000 is as follows: 1) $1.4 million to DHEC EMS; and 2) $4.6 million dollars for hospitals and physicians. The original proposal was 50/50 between hospital and physicians. The hospital money can be matched by Medicaid money if the money is put through the Medicaid program. There is no real significant increase for physicians' dollars if the money is put through Medicaid. Dr. Norcross stated that the disbursement subcommittee suggested that 50% of the hospital dollars (2.3 million dollars, with an additional match from DHHS), be put through the Medicaid fund, which will bring that total to 6.9 million dollars for the hospitals with 2.3 million for physicians. This amounts to twenty-five percent (25%) to physicians and seventy-five percent (75%) to hospitals. Dr. Norcross stated that the hospital funds will be divided between the different	

	trauma centers based on Illinois' definition of ICD-9 codes (which was established last year). Funds disbursement will be based on the total number of Medicaid population with injuries diagnosed and treated in trauma centers. Dr. Norcross stated that no hospital will receive less than $50,000, including Medicaid percentages. Dr. Norcross stated that there are 2.3 million dollars to be distributed to physicians. He stated that the disbursement scheme will be the same for physicians as it is for hospitals. **For example:** If MUSC received 10% of those dollars for the hospital, then it will also receive 10% of these funds for the physicians and if Grand Strand received 4% of those dollars for the hospital, then it will receive 4% for physicians. Dr. Norcross stated that another disbursement option would be to have DHEC distribute the money directly to physicians which would mean creating a beauracy at DHEC to look at charges and collections and distribute dollars accordingly. This option would be incredibly costly and would basically end up eating up the money from physicians to pay for the distribution system to send the money to physicians. The only other	

	alternative is to allow the hospitals to distribute the money back to the physicians. Dr. Norcross also stated that the trauma director from each hospital will be responsible for submitting a plan to DHEC on how to distribute the money to physicians at their hospital by June 1, 2007. This will also allow each trauma director to tailor the way the money is distributed at his hospital based on the particular circumstances of that hospital. A letter will be sent back to DHEC from the trauma director and/or hospital executive committee stating that the money was distributed in the manner so specified. Dr. Norcross stated that the minimum amount for hospital physicians will be $12,500. **One option** would be to divide up the money according to the unfunded care each physician provided. **Another option** would be a supplement to on-call pay, requiring a letter that states that this is a state allocation that varies from year-to-year and that it's not money from a hospital. Dr. Norcross stated that the most difficult step is for Trauma Directors to submit their disbursement plan to DHEC. One this is	

	done, the money should be distributed fairly quickly. Mr. Alonzo Smith stated that contracts between DHEC and the hospitals are being drawn up. Mr. Jim Walker stated that he will provide hospitals with a contract template that can be viewed and/or used by the hospital's legal department as a model to draw up contracts between the hospital and DHEC.	
Trauma Promotions subcommittee	Dr. Norcross stated that this is probably the single most important subcommittee created because its task is to come up with information on ways to inform the public about South Carolina's trauma system. He stated that in order to increase the amount of money that the State provides to the trauma system, the legislatives have to understand that this is something the public expects of them. This is not going to happen until the trauma system becomes high profile. One way is to have the Department of Transportation put a sign up letting the public know that a particular hospital is also a regional trauma center. Dr. Norcross stated that the response from the Department of Transportation was that "there is no difference in a trauma center than in any other ER". Mr. Greg Kitchen informed the Committee	A motion was made to have signs created by the Department of Transportation identifying hospitals as regional trauma center. The motion was seconded. The motion was approved.

	that he and Mr. Jim Walker will draft another letter to the Department of Transportation informing them that trauma is a legitimate system that is backed by legislation. Mr. Kitchens also stated that he will be coordinating meetings of the Trauma Promotions Subcommittee to look at ways to make trauma high profile and to inform the public about the trauma system in South Carolina.	
The next meeting	To be announced.	
Adjournment	There being no further business to discuss, the meeting was adjourned at 1:00 P.M.	

TRAUMA ADVISORY COUNCIL
August 23, 2007
Minutes

Members Present:
Dr. Doug Norcross (Chairman)
Dr. John Chandler
Mr. Troy Powell
Dr. Linda Veldheer
Dr. Paul Banish
Laurie Havice
Bill Manson
Ms. Kelly Hawsey
Mr. Lanny Bernard (Mr. Brian Hood)
Dr. Ed DesChamps
Ms. Nancy Owens
Dr. Lars Reinhart
Ms. Terri Schumpert
Cathie Osika-Landreth
Dr. Troy Privette
Dr. Raymond Bynoe
Ms. Holly Hayes

Others Present:
Mr. Greg Kitchens
Ms. Katrina Gary
Mr. Alonzo Smith
Mr. Jim Walker
Wilma Bocanegra
Ms. Debbie Couillard
Ms. Tammy Allison
Rodney Wilson
Matt Smittle
Mark Jones, MD
Elizabeth Burt
Brenda O'Connell
Diane Howell
Vicki Ellis
Richard A. Schmitt, MD
Barbara Bryant
Jane Marlowe
Lisa LeMay
Christina Grice
Quantella Rivers
Jeannette Summers

Agenda Items		**Motions/Actions Taken**
Call to Order	The meeting was called to order at 10:00 am.	
April 26, 2007 Minutes		A motion was made to approve the April 26, 2007 Minutes. The motion was seconded. The motion was approved.
Committee Reports:		
Chairman's Report	There were no specific chairman report; however, Dr. Norcross stated that several items would be discussed later in the meeting. Mr. Greg Kitchens welcomed Ms. Holly Hayes to the Trauma Advisory Committee.	
Trauma Registry/HOSCAP Update	Katrina Gary reported that as of July 16, 2007, HOSCAP is no longer used by South Carolina, and hospitals are no longer to use this website. She stated that DHEC is continuing to work on a contract with North Carolina Emergency Services Division to acquire the SMARTT system, which will take the place of HOSCAP. This system offers the same capabilities that HOCAP does, with a few extras.	
ABLS Course	Wilma Bocanegra stated that this is an online burn course, offering educational CMEs that was offered to	

	trauma physicians and trauma nurses at Level I and Level II trauma centers last year. There were approximately eleven (paid) slots left from last year that was offered to the level III hospitals this year. Ms. Bocanegra stated that she have two more (paid) slots left that anyone can use.	
Trauma Website	Greg Kitchens stated that updates to the trauma website are still in progress. He stated that DHEC will not let trauma have their own individual site, but they allowed trauma to use links to bring other information in. Some information was very outdated and has been removed. New information has been added, i.e., trauma regulations. The website will be a useful tool to communicate with hospitals and the public.	
ACS Books/Criteria Review	Dr. Norcross stated that a subcommittee was asked to look at the new 2006 version of the American College of Surgeon criteria for trauma centers and make revisions in accordance with the state's needs. Ms. Landreth stated that they have completed and sent out revision(s) for the level I and level II criteria. The subcommittee was not able to discuss Level III criteria because there was no Level III representation at the meeting. The ACS review committee is to meet again on September 4, 2007. Dr. Norcross stated that members of the Trauma Advisory Committee should receive all recommended revision(s) for review prior to scheduled Trauma Advisory Council meetings. Mr. Greg Kitchens stated that while they were reviewing the ACS guidelines, it became apparent that the State Trauma Plan also needed to be updated. Ms. Wilma Bocanegra has been putting a	

	lot of work into researching and updating this plan, which he is in the process of reviewing. He also stated that this would be a long process since the Plan has not been updated since 1995. Dr. Bynoe stated that the ACS Subcommittee found that the national criteria used for the different levels do not deviate much from what the State of South Carolina requires.	
Trauma Promotions Subcommittee Report	Mr. Greg Kitchens stated that the last meeting of August 15, 2007 was mostly to lay the groundwork to figure out which direction to head. Promotional ideas and the need to get the general public involved were also discussed. Mr. Kitchens stated that the general public does not realize that there is a difference between trauma centers and hospital ERs. The subcommittee also established a goal of reaching politicians for funding. Ms. Terri Schumpert has made contacts that will provide promotional paper billboards. They are also looking to provide pamphlets and/or brochures. Mr. Kitchens stated that the Hospital Association has been very instrumental in the past with helping to provide these materials. The subcommittee will also have to come up with ideas on how to pay for these costs, either by fundraising methods or through donations. Mr. Kitchens stated that the biggest problem is where to get the funds to pay for these costs. Ms. Terri Schumpert stated that the subcommittee also discussed a nationally recognized symbol for trauma. She stated that she is looking at different ideas across the nation to see what they are doing to develop their	

	awareness. Ms. Schumpert stated that they also discussed bringing in some Public Relations experts, perhaps from the hospitals to come to the Trauma Promotions Subcommittee meetings to speak with them about possible promotional ideas. Dr. Bynoe stated that the American Trauma Society uses a red rose as their national symbol. Dr. Norcross asked if any of the trauma funds was earmarked for advertising the trauma system. Mr. Kitchens stated that there are no specific funds for advertising the trauma system.	
Trauma Regulations	Mr. Kitchen informed the council that the framework for the regulations has been posted on the website @ http://www.scdhec.gov/health/ems/Trauma%20Regs.pdf. He stated that the regulations would change significantly prior to being approved and published within the next year. He also stated that he has received some comments and several phone calls with questions regarding the regulations. Mr. Kitchens stated that the comment period would end on August 28, 2007. There will be another comment period when the regulations are published again. Dr. Norcross asked Mr. Kitchens what happens between the two comment periods. Mr. Kitchens answered that the trauma regulations subcommittee will meet and discuss the comments that he have on hand from this comment period to determine which ones are legitimate. The subcommittee will then present their recommendations to the DHEC board and then the state registry for another comment period. The time frame will be approximately three to four months	

	before the next comment period begins.	
EMS Advisory Council Report	Mr. Smith stated that the EMS Advisory Council advises the Department on issues relating to EMS. Within this council are the training committee and the Medical Control Committee. The EMS regional offices makes training reports on types of training courses at the national registry level for paramedics, intermediates and block grant courses. There is also a trauma report given by the Trauma Manager or designee. Mr. Smith stated that the Medical Control Committee oversees the scope of practices for the EMS Division.	
TASC Report	Ms. Landreth reported that TASC has completed the revision of the application criteria for level I hospital designation and gave these to Greg Kitchens. The Trauma Symposium is November 8-9, 2007. Brochures for the symposium have been completed; nurses are encouraged to attend the symposium. She also stated that they are still awaiting an update on changes to the trauma registry. The national trauma data bank has certain specifications that hospitals are to meet and Collector is updating this information. When updates have been completed, hospitals will be in compliance with the national trauma data bank. Dr. Norcross asked what the reason for delay was. Ms. Katrina Gary answered that Digital Innovations was one reason for the delay and there were also some HIPPA compliance issues with sharing information, which has now been cleared up. She also stated that	

	Digital Innovations has given her a date of August 28, 2007 when they will send out those updates, at which time hospitals can begin dumping their data. Mr. Gary stated that once all the hospitals are sending data on a state level; she will be able to provide reports based on specific needs of the requesting entity. Dr. Norcross asked TASC to look at the mechanism(s) for pulling data.	
Old Business: Distribution of Physicians/Hospital Funds	Dr. Norcross stated that a plan for distribution of state money for trauma centers and physicians was approved at the April 26, 2007 meeting of the Trauma Advisory Council. There were six million (6,000,000) dollars allocated by the State of South Carolina to support trauma. **Breakdown**: 1.4 million was earmarked for EMS services and DHEC EMS Division for their administrative cost; the remaining 4.6 million dollars was earmarked for distribution to physicians and hospitals. The original plan was to split that money 50/50, which left 2.3 million dollars for physicians and 2.3 million dollars for hospitals. The 2.3 million dollars for hospitals would then be matched with federal dollars through the Medicaid program, bringing the total to 6.9 million dollars for hospitals and 2.3 million dollars for physicians. Dr. Norcross stated that DHHS (Department of Health and Human Services) did not agree to the matching funds. Dr. Norcross suggested that the original methodology be used to distribute the money based on the percentage of	

	Medicaid and un-funded patients that a particular hospital treated that were trauma patients, according to ICD-9 Codes. The only difference in the disbursement scheme is the lack of Medicaid matched funds, without which drops the total to 4.6 million dollars instead of 9.6 million dollars. Dr. Norcross stated that initial split of 50/50 actually ended up at a 75/25 split for hospitals and physicians. Dr. Norcross also stated that they must now come up with a different disbursement option since they no longer have the Medicaid match funds. The decision is to either divide the money 50/50 or 75/25. A question arose on who would decide the method of allocation at the hospital level. Dr. Norcross answered that either the Trauma Director and/or the hospital medical executive committee would draft plans for distributing physicians' dollars and make their plans available to the Advisory Council. Mr. Alonzo Smith stated that it is at a critical stage for these funds to be disbursed because the proviso for this year has changed. Although this does not affect the hospitals and physicians' funds; it does complicate the process of trying to get these funds disbursed. He also stated funds need to be disbursed because it will be very difficult to ask for additional trauma funding when there is trauma money that is not being used. After some discussion; it was decided that the funds disbursement committee meet again to discuss other	A motion was made for the funds disbursement committee to meet again to put forth revised option(s) for disbursement of hospital/physicians' trauma funds with a goal of having this meeting completed by September 15, 2007. The motion was seconded. The motion was approved.

	disbursement option(s).	
Statewide Trauma Triage Protocols	Dr. Norcross stated that the triage protocol is on the agenda for Medical Control the following week. He asked if there any concerns that needed discussion. Dr. Richard Schmitt stated that his concern centered on the third paragraph, second sentence of the protocols, **as reads**: A lower-level center should not be bypassed to transport to a higher-level trauma center. If no trauma center is available, transport to closest appropriate hospital emergency department for evaluation and transfer as necessary. Dr. Schmitt stated that from the perspective of level III hospital, this statement would cause significant patient safety issues. Dr. Schmitt stated that the wording of this statement would preclude these hospitals from caring for trauma patients, as it would cause a delay in transferring patients to an appropriate center. Dr. Schmitt asked the Committee to consider changing the language. Dr. Schmitt stated that these patients should, at the least, be transported to a level III trauma center. Dr. Norcross asked the members of the Council if they all agreed to the first two sentences of paragraph three and they all agreed. He reiterated that Dr. Schmitt's concern is the last sentence, which states that "if no trauma center is available, transport to closest appropriate hospital emergency department for evaluation and transfer as necessary". Dr. Schmitt affirmed that this is one of his concerns with this mechanism. Secondly, if this statement is going to stay,	

	then the word **not** in the statement which reads: "A lower-level center should **not** be bypassed to transport to a higher-level trauma center", be changed. Dr. Mark Reynolds stated that when you get to the third level in the mechanism; certain things have already been ruled out, i.e., shock and severe injury. Therefore, protocol would not be to transfer to a level III trauma center because the closest appropriate emergency department would be able to handle this patient. Dr. Norcross shared what the American College of Surgeons said regarding this mechanism, which reads: **"Transport to the closest appropriate trauma center which, depending on the trauma system; may not be the highest level trauma center".** Dr. Norcross suggested looking into the meaning of the phrase **"if no trauma center is available"** because some counties do not actually have a designated trauma center. Dr. Schmitt agreed that the ACS language would work well in this particular circumstance; however, there are still facilities within the state that would not be appropriate to handle this patient; thereby, requiring transfer to a level III trauma center. Dr. Norcross stated that the ACS language is based upon the assumption that all areas are covered by trauma centers, which is not the case in South Carolina.	A motion was made to change the language in paragraph three, sentence two, from **not** to **rarely,** which would now read: "A lower level trauma center should **rarely** be bypassed to transport to a higher level trauma center. The motion was seconded. The motion was approved.

	Dr. Schmitt again asked the council to consider changing the word **not** in paragraph three, sentence two to **rarely.** After much discussion, it was agreed upon by the council to change the language in paragraph three, sentence two. Dr. Norcross asked if there were any more items for discussion. Dr. Bynoe asked that hospital infrastructure be placed on the next agenda.	
Adjournment	There being no further business, the meeting was adjourned at 12:30 P.M.	
Next Meeting	October 25, 2007	